The Voice of Accountable Physician Groups

Status of Delegated Model Physician Groups

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FSSB Meeting, Sacramento

June 18, 2014

The Environment

Delegated Model groups historically operate in three main areas:

- Medicare Advantage HMO
- Commercial HMO
- Medi-Cal Managed Care

Enrollment by payer source is tracked on www.cattaneostroud.com.

Trends

- Some group consolidation, especially in the north
- Competition between groups, especially in the south, and even new groups formed
- Formation of foundation-model integration with hospitals has been significant
- Financial status has been stable generally, but less so where high percentage of MMC lives

Forecast

- ACA calls for integration, coordinated care, supporting delegated model base
- ACO experiment – tough sledding
- Overshadowed by MA enrollment growth
- Revenue cuts with loss of cross-subsidization between product lines
- Uncertain policy in Covered California
- Need for evolution of model

Medicare Advantage

Medicare Advantage

- Historically the best-paying capitated payment source
- Groups with high MA enrollment among the most solvent
- MA DSNP enrollment preserved in state budget deal for 2015 – will stabilize groups
- MA enrollment has funded care management infrastructure in delegated model groups

Medicare Advantage Final Rate Notice

- Average 7 percent cuts, but varies by region across California, for 2015
- Add on 2.5% ACA premium tax passed through by MA plan to capitated provider
- 8-10% cut in capitated revenue
- Can it be offset by continued steady growth in the MA population?
- Enrollment percentage grew from 10% to 51% in 2013 among all newly eligible seniors

The New Reality of MA

- ACA calls for parity with Medicare FFS resulting in cuts to program funding, but seniors are choosing MA more frequently
- STARS plan rankings are key to stability
  - 3 star plans will face more cuts in 2015
  - 4 star or higher will receive bonuses
  - MA plans narrow networks to high performing groups to maintain effective STAR rankings
- Groups in 4 star plans will prosper, others less so

Cal Medi-Connect

- DSNP enrollment in existing non-CMC plans is preserved for 2015 – will stabilize groups
- Plans in CMC that are 3 stars may face probation, and will lose bonuses
- New Duals population will be difficult to handle under reduced capitation rates
- Groups in higher-ranking plans that have percentage of premium revenue will be more stable than groups in lower-ranked plans

In Sum…

- Medicare Advantage revenue is leaning out
- Plans will utilize higher-performing, narrower networks to maintain high STAR rankings
- This will increase the divide between the “have” and “have not” physician groups
- While enrollment is increasing, volume may not make up for decreased revenue
- MA will no longer be as much of a stabilizing force in the delegated model

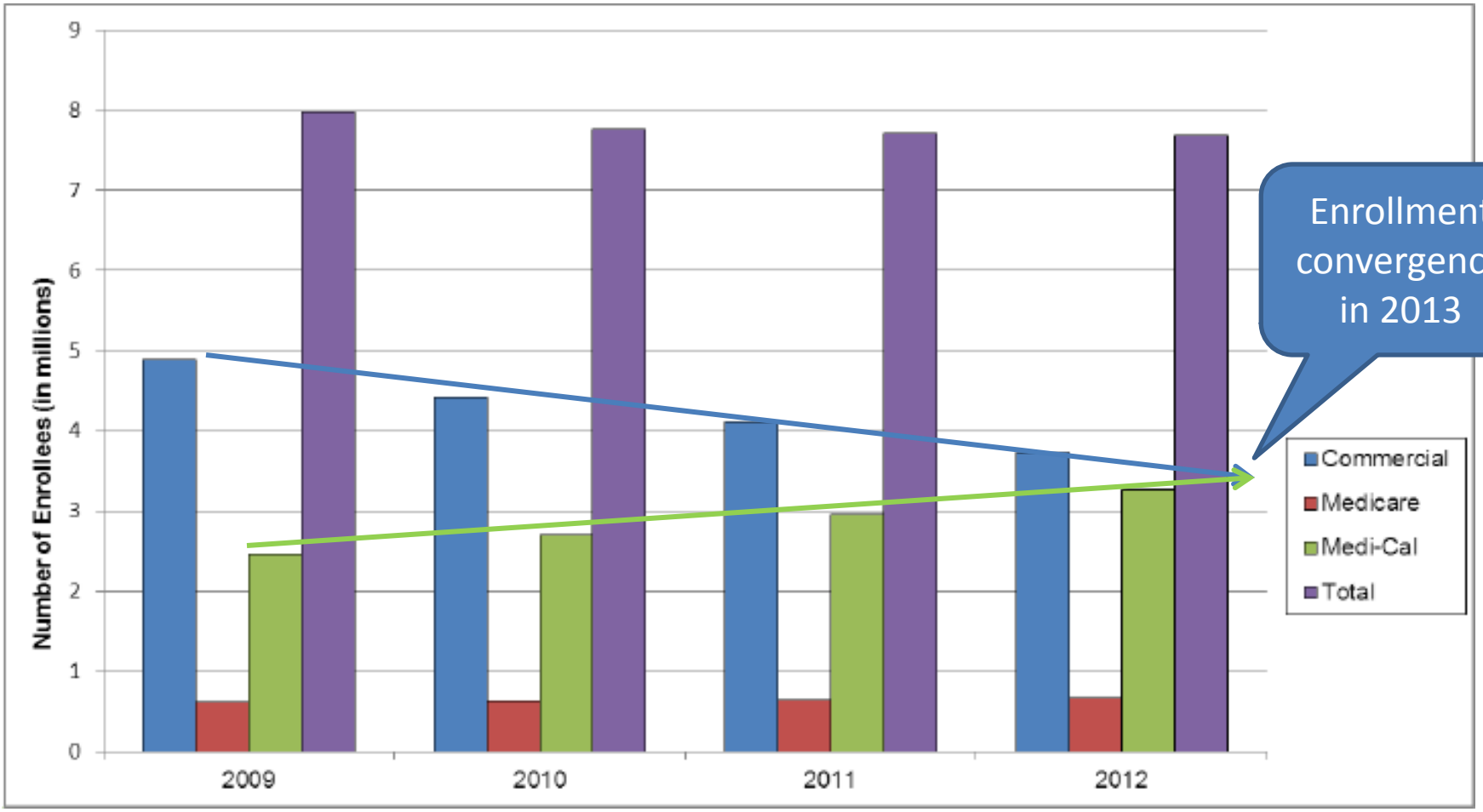
Commercial Payers

Impacts in Commercial Model

- Continued erosion of employer-sponsored HMO enrollment
- Covered California appears to be a directly-contracted PPO market, will not feature delegated model networks – no growth there
- November 2014 Rate Review Ballot Measure threatens cross-subsidization of MMC by commercial payer sources
- Future growth tied to expansion into ERISA employer plans

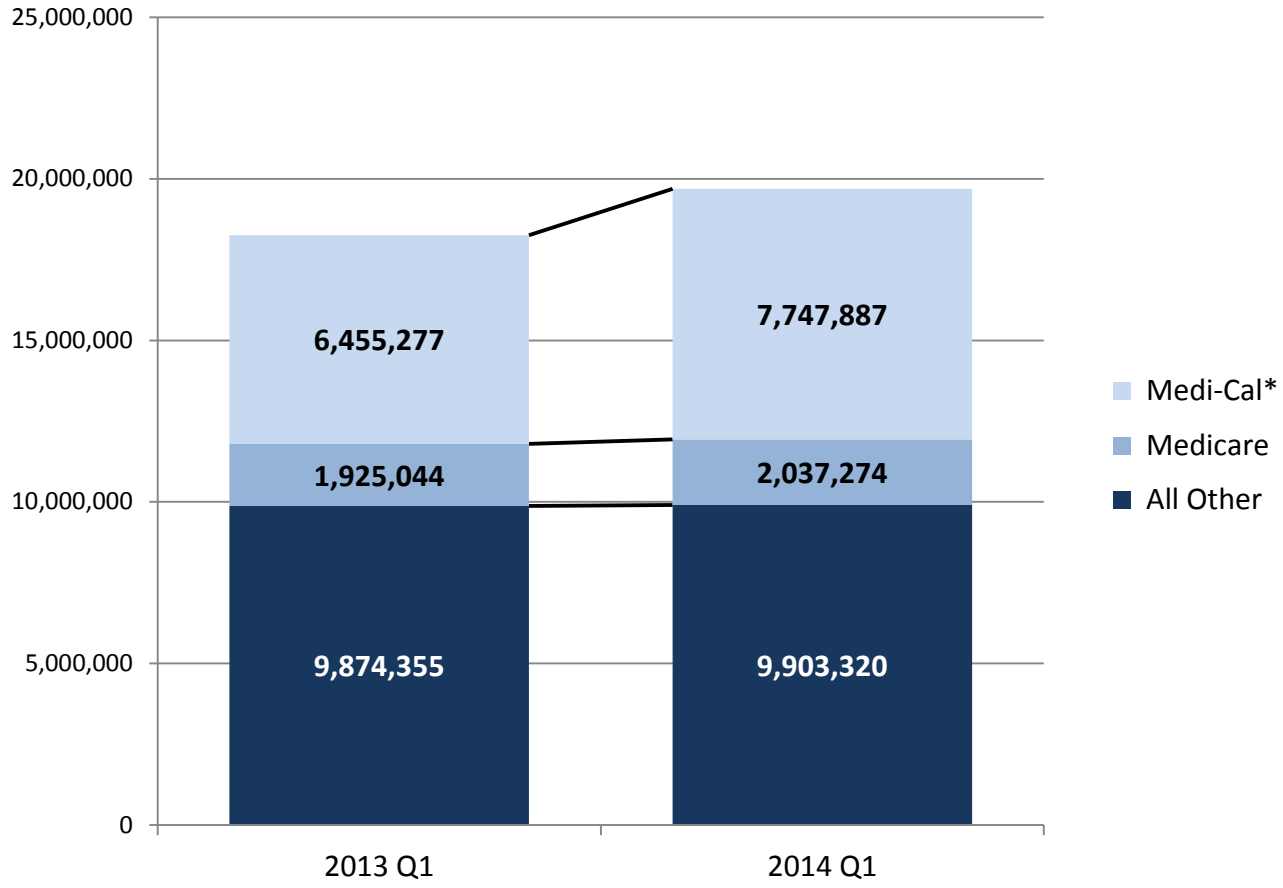
Commercial & MMC Enrollment

Non-Kaiser Permanente Delegated Model Enrollment in 2013



Source: Gil Riojas report, August 31, 2013 FSSB Meeting

California HMO Members - 2013 to 2014



- Preliminary HMO membership estimates for 2014 show a 7.9 percent growth (1.4 million member increase) over 2013 – the strongest growth in over a decade.

* Medi-Cal includes Health Families enrollment

Source: DMHC Financial Summary Data [http://wpso.dmhc.ca.gov/flash/ accessed June 4, 2014). Membership calculated as Total less Point of Service, PPO, ASO, IHSS, Medi-Care Part D only, Medicare Cost, and Plan-to-Plan members.

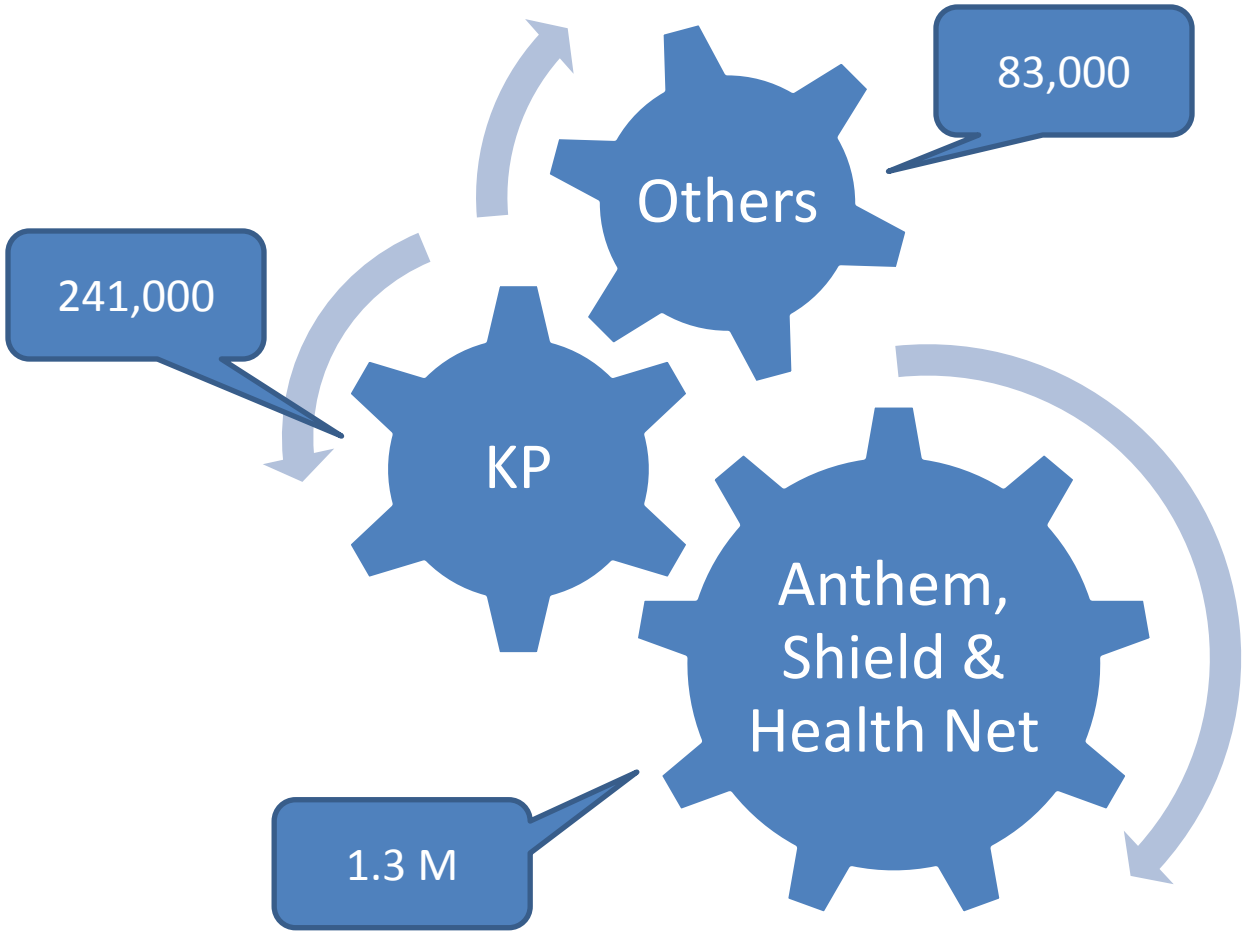
Covered California March 2014 Enrollment Growth by Plan

Plan	Jan-14	Feb-14	Mar-14
Anthem Blue Cross of California	223,630	268,204	**425,058**
Blue Shield of California	213,646	245,632	**381,457**
Chinese Community Health Plan	7,657	9,720	14,306
Contra Costa Health Plan	668	774	1,091
Health Net	125,550	154,414	**264,079**
Kaiser Permanente	131,434	158,372	241,098
L.A. Care Health Plan	12,439	16,208	38,124
Molina Healthcare	4,482	4,614	11,731
Sharp Health Plan	5,998	7,476	13,087
Valley Health Plan	815	1,017	1,891
Western Health Advantage	1,697	2,159	4,007
Total	**728,016**	**868,590**	**1,395,929**

- Data include individuals who finished their applications and selected plans through April 15, 2014.

Source: http://www.coveredca.com/news/PDFs/regional-stats-feb/Feb_Regional_Tables.pdf, http://www.coveredca.com/news/PDFs/regional-stats-march/March_RegionalEnrollmentTables_forWeb_ss.pdf

Exchange Plan Enrollment



Comparison of Physician Overlap between Plans in California Covered California Vs Timely Access Reporting

Covered California-2014

Plan	Blue Shield	Anthem	Health Net	Kaiser	All Other CC Plans
Blue Shield	**43,579**				
Anthem	24,185	**37,555**			
Health Net	4,097	3,781	**4,697**		
Kaiser	412	747	13	**13,420**	
All Other CC Plans	10,734	9,775	2,399		**13,707**

Timely Access Reporting-2013

Plan	Blue Shield	Anthem	Health Net	Kaiser
Blue Shield	**57,985**			
Anthem	51,198	**60,029**		
Health Net	40,062	40,644	**45,216**	
Kaiser	2,364	2,848	1,968	**16,107**

Covered California Provider Listings, Winter 2014; Medical Group responses, March 2014. 2013 Timely Access reporting, DMHC PRA request.

Narrower Networks in Exchange

- Anthem has 425,000 lives in Covered California but is using 37,000 physicians rather than its full panel of 60,000.
- Blue Shield has 381,000 lives and is using 47,000 out of 58,000 physicians
- Health Net gained 264,000 lives but reported only 4,697 doctors in Covered California out of its full panel of 45,000

Group and Physician Participation by Plan Product

	CAPG Groups	Groups	Physicians
Blue Shield	138	6,329	43,579
Blue Shield-EPO (Exclusive) (Individual)	95	1,492	5,899
Blue Shield-HMO (Exclusive) (SHOP)	111	2,971	15,423
Blue Shield-HMO (Full) (SHOP)	53	650	2,529
Blue Shield-PPO (Exclusive) (Individual)	130	5,291	33,068
Blue Shield-PPO (Exclusive) (SHOP)	126	5,265	29,745
Anthem	66	1,878	37,555
Anthem-EPO	17	140	3,219
Anthem-EPO (Individual)			2,209
Anthem-EPO&HMO	62	1,332	20,233
Anthem-HMO (Individual)			12,670
Anthem-HMO&PPO	32	337	3,406
Anthem-PPO	39	797	7,963
Anthem-PPO (Individual)			2,209
Health Net-HMO (Individual)			4,697
Kaiser-HMO (Individual & SHOP)	2	2	13,420
Chinese Community-HMO (Individual & SHOP)		1	277
Contra Costa Health Plan-HMO (Individual)	6	119	2,321
L.A. Care-HMO (Individual)	6	12	2,584
Molina-HMO (Individual)	17	327	5,190
Sharp			1,340
Sharp Health-HMO (Performance) (Individual & SHOP)			1,340
Sharp Health-HMO (Premier) (Individual & SHOP)			919
Valley Health-HMO (Individual)		19	1,907
Western Health-HMO (Individual & SHOP)	5	11	1,780

Covered California Provider Listings, Winter 2014; Medical Group responses, March 2014.

Medi-Cal Managed Care

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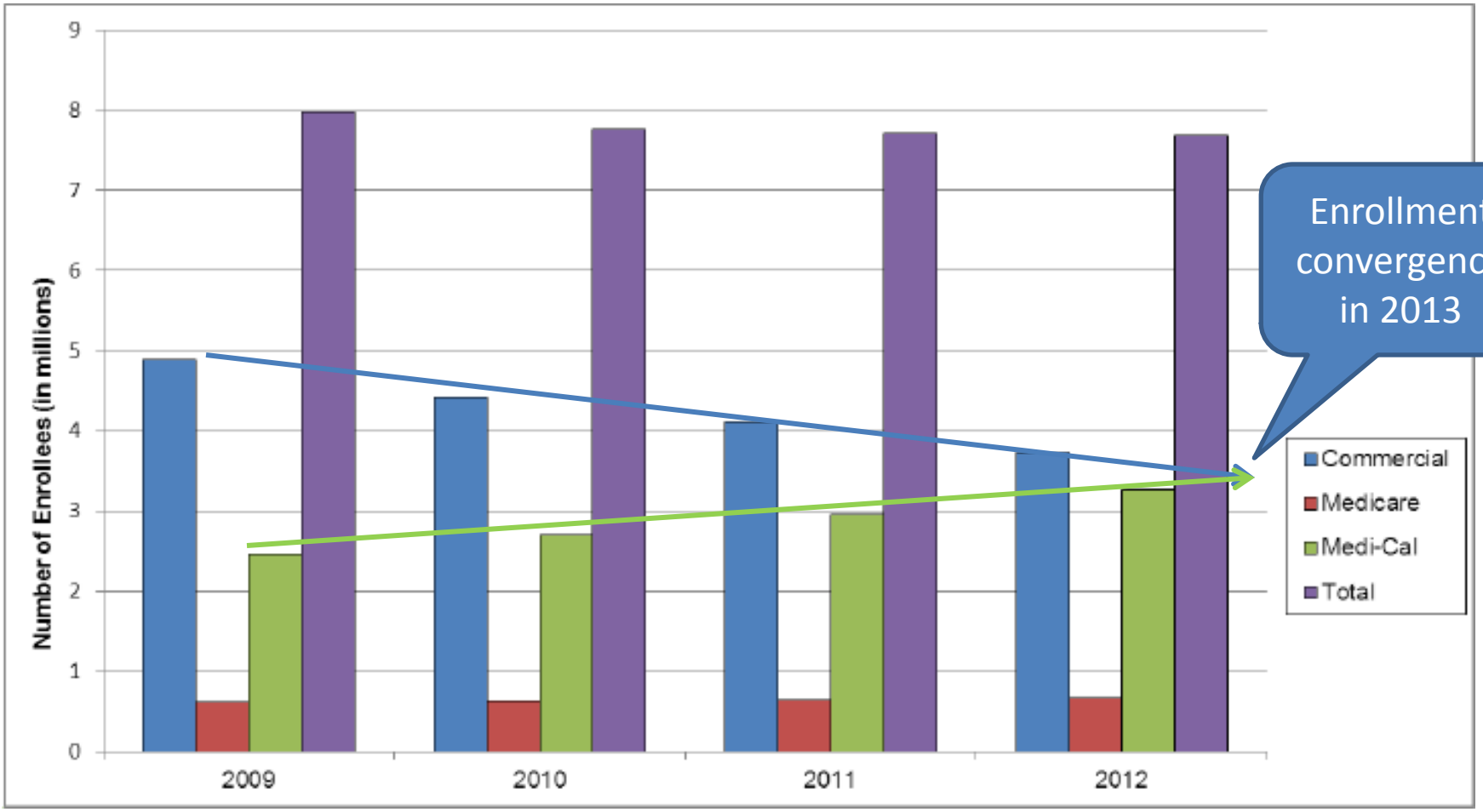

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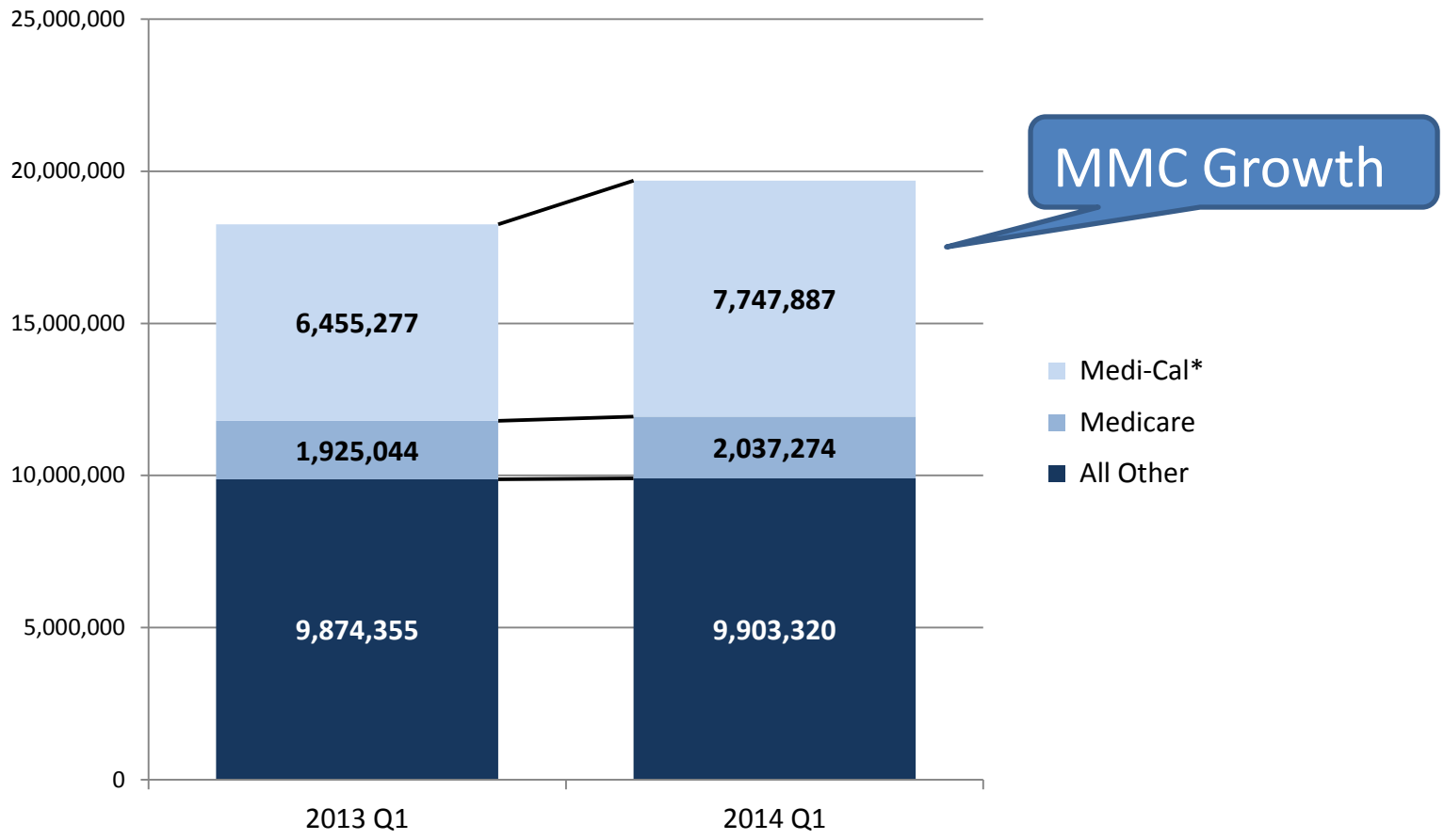

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MMC Enrollment Growth

- Lowest cost structure of all three major payer sources, but fastest growth
- Milliman analysis for CAPG of Cal Medi-Connect capitation rate showed underpayment similar to the prior SPD experience
- Percentage of Premium (SB 208) implemented at 23% of cap dollar – opposite of MA Plans
- MLR is uncertain in some plans - investigate

MMC Medical Loss Ratio

- Federal law exempts MMC plans from MLR regulation
- DHCS is the “enforcement” entity – imposes MLR by contract with MMC plan
- DMHC can only monitor
- Indication that some plans are paying combined physician and hospital cap in the 55-60% range. Add 10-15% for drugs, still fails to add up to 85 percent.

Shared Risk Pools

- MMC plans use shared risk pools between delegated physician groups and hospitals, require partnering to obtain capitated lives
- Pools are underfunded and dry up. Hospitals demand backfill from group or threaten to pull out, causing group to lose assigned lives
- Backfilling a deficient risk pool for hospital costs is akin to taking institutional risk w/o a Knox Keene license

Potential Solutions

Physician Group Solvency

What is a Restricted License?

- The DMHC and its predecessor agency, the Dept. of Corporations, have licensed several “limited” and “restricted” entities over the years
- Such licenses allow the licensee to accept both institutional and professional risk-based payments as subcontractors to full-service plans
- These licenses do not allow the entity to market coverage directly to enrollees, like a full-service Knox Keene Health Plan

History of Licensure

- Generally, the Department has required restricted licensees to file all of the sections of the application except the marketing sections.
- The Knox Keene Act does not define a limited or restricted licensee, although the DMHC does acknowledge their existence under its health plan list.
- No formal guidance or regulation has ever been issued and it could be argued that this practice amounts to an underground regulation since the filing requirements have varied over time

Purpose of the Regulation

- To “codify” a long-standing process at DMHC
- To encourage licensure, and the increased financial oversight that ensues from it
- To differentiate from “health insurance issuers” under the ACA
- To recognize emerging functions of full-risk entities, like ACOs, direct relationships with self-funded employer plans and to provide an alternative to shared-risk pools

Accountable Care Organizations

- The Pioneers had licenses or acquired them in advance of downside risk in year 3
- There is a rapidly developing federal policy on "ACO 2.0" that includes "global payments" to such entities. This will require state licensure.
- California has led in other areas of the ACA implementation – this is another opportunity
- The proposed rule supports a "Multipayer" strategy for such entities

Proposed Submittals

- CAPG has drafted a regulation and statement of reasons
- Per previous discussions with the Department, a section following the main application was selected as the best placement
- A regulation was chosen over legislation, because of the 30 year practice of granting such licenses, and the evolution from “limited” to “restricted” for Medicare Advantage, without prior legislation

Structure

- The regulation identifies a “restricted” license
- Calls out that it is not a “health insurance issuer” and cannot market coverage
- Must meet all financial requirements of a full-service plan – including periodic monitoring
- It can subcontract with a fully-licensed plan, directly contract with a government payer (Pioneer) or self-funded employer plan

Grandfathering

- Recognizes prior “limited” and “restricted” licensees in good standing on the effective date of the new rule
- Allows for new contracts based on amendment filings rather than material modifications, where acceptable – obviously not in cases of service area expansions, etc.
- Creates a recognized category of full-risk bearing entity between a full-service plan and an RBO.

Protections

- Greater oversight of financial conditions that currently exists for RBOS that are part of a shared-risk pool arrangement
- Resolves the ACO-licensing discussion
- Reporting and monitoring of the whole entity unlike current RBO situations
- Additional risk requires the same capitalization of reserves as a full-service plan

Request

- CAPG asks DMHC to consider issuing such a regulation in 2014 and to convene a stakeholder process to discuss the economic, regulatory and policy reasons for such a regulation at this juncture in California coverage expansion
- Dovetailed effort with Wyden “Better Care Act” in the Congress